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Opioids: Use, Abuse and Treatment¹

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Opiates have been around for thousands of years; originally it was seen as a magic drug that could cure anything. The discovery of opiates alleviated the pain of injury and sickness, an example of this is seen in its early use with women. Women were seen as fragile human beings who should not experience any type of pain, physical or emotional and opiates were given to them to alleviate any pain they may experience. It was socially accepted that women, and men who had come home from the war who were addicted to opiates, because they were seen as a fragile part of society. Society felt that addicted individuals had medical problems and there was given a great deal of tolerance to these populations. Doctors would prescribe medication for these groups of individuals and because of this The Harrison Act of 1914 was created. It made it illegal for doctors to continue to prescribe opiates to individuals who had become addicted to opiates.

Opiates come in many forms and can be abused in a variety of ways. They can be prescribed by doctors for pain control, they can be found on the intranet or in medicine cabinets. Heroin is sold on the street and is often used after pain pills have become so expensive for the addict to obtain. Opiates change how the brain processes pain and emotion; they numb a person both physically and emotionally. It takes time for a person who has become addicted to opiates to retrain how their body responds to pain as well as to learn how to deal with all emotions. Pain pills have become a common problem today. Doctors continue to prescribe pain medications to individuals sometimes without taking into account the addiction vulnerability of the individual.

Individuals who use opiates may become physically dependent upon opiates and not become psychologically addicted to them. Physical dependence will create withdrawals in patients but can be managed by tapering off opiates in an appropriate manor. Those who become dependent and addicted to opiates struggle because of the fear of the withdrawals, so they continue using to “stay well”, they no longer feel that they are getting high off the drug. Withdrawal can be very individual, there are physical and psychological withdrawals and many are unable to deal with either challenge.

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In the 1950's death rates began to climb because of heroin overdoses, a committee was formed to help find ways to deal with the addiction to opiates. Methadone became a very useful option for those addicted to opiates. It started out as a test because there were too many people addicted to opiates, crime rates had increased and a solution needed to be found. It had a great deal of success; because it was a long acting medication that only needed to be taken once a day. It was taken as a liquid dose, in a clinic setting. An individual does have to be addicted to opiates in order to take methadone on a long-term basis, except a woman who is pregnant she can be given methadone as soon as she becomes physically dependant upon opiates. This is done because it can be unsafe for the fetus to experience withdrawal.

Suboxone is a sublingual pill that is to be placed under the tongue and should be allowed to dissolve in order to get the full effects of the medication. The average dose is between 12-24 mg and 32 mg is the highest dose a person should be taking of Suboxone. Suboxone can also be given every other day and does not have to be administered in a clinic, doctors can prescribe it. Vivitrol is an injection that is given once a month; the cost is approximately \$900.00 per month.

Babies who are born dependant on opiates can go through withdrawal, usually within the first 72 hours after birth. They experience the same type of withdrawals that adults experience. When pediatricians are aware that the mom is on an opiate or some type of maintenance therapy, the baby is monitored for withdrawals. If the baby shows signs of withdrawal, medication is administered to ease the symptoms. Methadone and Suboxone are safe medications for the fetus.

Medication assisted treatment for opioid addiction has been proven to be an effective treatment to support long-term sobriety. There are positive reasons to include medication in the treatment of opiate addiction. First, it gives time for the brain to heal, next it gives time for the patient to work through the issues that created the need to abuse opiates in the beginning and finally, it addresses the psychological dependence people often feel with an opiate addiction.

The History of Opiates

Opiates have been a part of society dating back about 4000 years. Arab's introduced opium into China between 600 and 900 A.D., China introduced opium to Europe and its use quickly became widespread. China stopped importing opium into Europe in the early part of the nineteen century leading to war. Opiates have been found in archeological sites in Asia, Egypt and Europe. People in The United States have used opium throughout history, with the average housewife as the major user of the drug (Kuhn, Swartzwelder, Wilson, 1998).

In 1805 morphine was purified out of the opium poppy; then in 1853 the hypodermic needle was invented which made it possible to inject morphine. The hypodermic needle and morphine became a very valuable way to treat the wounded during the Civil War. In 1898 the Bayer Company added a medication to the morphine to make it fat-soluble and gave it a more rapid way to get to the brain, this created heroin. (Kuhn, Swartzwelder, Wilson, 1998) Courtwright, 2001, stated that when morphine was injected it created fewer problems with the stomach; it had a stronger, more rapid effect on the patient and made it a more favorable way to use than being taken orally.

Opiates were used to treat wounded men and treat people with cholera and dysentery. They were given to women so they did not have to endure any type of uncomfortable physical or emotional pain. "During the nineteenth century the typical opiate addict was a middle-aged white woman of the middle or upper class (Courtwright, 2001)." Kendall (2001), states that women who were of higher status used opium to bring about a peaceful feelings and gave them the ability to forget their pains and ailments. In the late 1800's women who suffered with "female problems" were given opiates to help them with the pain. "R.V. Pierce, who built a huge business based on opiate-laden medications, advised that when woman, "the last and crowning handiwork of God... is disturbed by disease, when the nicely-adjusted balance of her complex nature deviates from its true and intended poise...its importance should elicit...the scientific administration of the choicest, rarest, and purest medicinal elements in the whole range of nature (Kendall, 2010)." Many women turned to prostitution to support their habit and opiates had an added benefit because it stopped them from menstruating. This became a good way to prevent pregnancy as well as it made it possible for them to work all the time with out having to take time off because of their menstrual cycle. Women who were of a higher class would also use some form of opiates as a form of birth control when they were indiscrete (Courtwright, 2001).

In 1914 Congress passed the Harrison Anti-Narcotic Act which ruled that doctors could not prescribe narcotics to help with addiction maintenance. For all intense and purposes this act made it illegal for doctors to prescribe opiates unless the person was a patient, which forced many women who were addicted to do whatever they could to support their habit, for many this took the form of prostitution (Kendall, 2010). The Harrison Act was not put into place to prohibit use but more to regulate manufacturing, distributing and prescription of opioids, coca and derivatives. The physicians were required by this act to be licensed, keep records for inspection and pay fees to the US Department of Treasury (Medication-Assisted Treatment, 2005).

Different Forms of Opiates

Heroin has become a popular form of opiates, possibly because it is less expensive. It is processed from morphine and it is typically sold in white or brown powder. It can be cut with other household products and it is sold on the street. Heroin can be smoked, sniffed or snorted, it can be injected either intravenously or into the muscle. The fastest way to get the effects of the drug is through IV injection, this rush happens in 7 to 8 seconds. Once heroin hits the brain it is converted to morphine and it binds to the opioid receptors. It is very addictive because it gets to the brain so quickly. The rush will include the skin getting warm, while their arms and legs begin to feel very heavy. Users will be drowsy for quite a while and their mental function will be clouded by the effects of the heroin. Some will experience itchy skin, nausea and vomiting as well. Their breathing and heart rate can slow down which is why this drug is so dangerous because they will not know if they are overdosing. In the 2003 National Survey on Drug Use and Health, it was estimated that 3.7 million people have used heroin at sometime in their life (NIDA, Research Report Series, Heroin, 1997). "According to the Office of National Drug Control Policy (ONDCP), there were an estimated 810,000 to 1,000,000 individuals addicted to heroin in the United States in the year 2000, which is the highest number since the mid-to-late 1970's (Clinical Guidelines for the Use of Buprenorphine, 2004)." The reason may be that heroin is between 50-80% pure which has made heroin easier to get high by other routes such as smoking or snorting. It is also reported that because of the simplicity of use we see a higher rate of opioid users, leading to more overdose deaths and emergency room visits.

Heroin has disappeared and reappeared at different times in history. The 20th Century has not been an exception. Although by the 1940's it began to disappear because of cost and stricter manufacturing quotas. By the 1950's there were a few big cities that had not struggled with heroin addiction, it seemed to be an urban problem. 1960 and 1970's brought about a round of heroin addiction, this was known as the baby-boom phenomenon (Courtwright, 2001).

In 1970, the Comprehensive Drug Act was passed by Congress. This put narcotics and psychotropic drugs into five schedules. They were categorized on their abuse potential, medical value and safety. Schedule I drugs have no therapeutic value and no value to physicians, these included heroin, marijuana and hallucinogens. Schedule II through V have therapeutic value, the schedule they are categorized depends on their degree of value (Courtwright, 2001). Pain medications are Schedule II drugs, these include Oxycodone, Percodan, Percocet, Loretab, Dilaudid, Vicoden, Phentenal patches and Oxycotin.

Dr. Pinsky's (2004), reports that Oxycodone was developed in Germany, originally it was given by injection, then in the 1950's it was combined with different medications. This new medication is known as Percocet (with Tylenol) and Percoden (with aspirin), they could be taken orally and had a relatively fast onset, the problem then was that the effects did last very long so Oxycotin was made. Oxycotin has a slow release and lasts up to 12 hours; it is as much as 25 times stronger than Oxycodone. All of these medications can be taken orally; however, addicts will usually crush them and then snort them, this creates a more rapid absorption. They can be injected as well but it takes more time to prepare it for injection. Oxycotin has become a popular drug to abuse; it can be purchased on the street or from the Internet.

"Most opiate drugs are easily absorbed into the body from many different routes, mainly because they dissolve in fatty substances and can cross into cells (Kuhn, Swartzwelder, Wilson, 1997)." All these drugs have the potential of abuse because they each bind to the same molecule in the brain. The differences in the drugs are how fast they reach the site and then how much it takes of them individually to activate the receptor.

Today we have a new wave of opiate abuse, prescription drugs, the speculation for this is that they are easier to obtain, there is less stigma to them and they continue to be easily available by internet. In 2005, there were an estimated number of 6.4 million people who have used psychotherapeutic drugs non-medically, of those 6.4 million people; 4.7 million had used pain relievers, with the average age being 21.2 years of age. Today there are many people able to obtain these drugs from family medicine cabinets because of the popularity of doctors prescribing the medications (Webster, Dove, 2007).

Opiates Used for Pain

In the mid nineteenth century narcotics were used to treat pain, during this period of time morphine was termed "God's own medicine". Doctors still prescribe opiate medication for pain. The majority of doctors have very little training on addiction, and often they do not ask questions of their patients that might lead them to be concerned of any addiction. Dr. Pinsky (2004) reports that as a medical student he had a patient who was in severe pain and he gave his patient morphine in the IV; he describes the situation with the patient as "Within seconds, his breathing became slower and deeper. A calmness swept across his face. As he became more comfortable, I remember my sense of awe and excitement that I had been able to help this man who had been suffering". Dr. Webster (2007), a physician who works with chronic pain wrote

that doctors need two sets of skills when prescribing narcotics, one to prescribe and the other to minimize the risk of abuse. He states “prescription opioid abuse is a growing phenomenon that no ethical health practitioner can ignore. The correct use of language will help clinicians and patients to more precisely identify and address the various clinical conditions related to pain and the use of opioids”.

There are some questions that should be asked when a doctor is planning to prescribe opiates for longer periods of time. These questions would make it easier for doctors to determine if their patient is at risk of addiction. Dr. Pinsky states that patients who have a history of addiction or have suffered some type of trauma such as sexual abuse or PTSD are more susceptible to addiction. People who have low self worth or have a difficult time managing their emotions are more drawn to opiates because they have the ability to feel emotionally numb. He reports that some patients have stated they finally felt normal after they had taken opiates. Dr Webster said that preadolescent sexual abuse, mental disease or pain that is not controlled appropriately can also cause someone to be more susceptible to addiction.

Physical dependency vs. addiction

Any one who is taking opioids for long periods of time will become physically dependent to the medication because the body becomes accustomed to the medication. “In order to become addicted to an opiate, one must first become physically dependent, that is, experience withdrawal symptoms if the drug is discontinued. In order to become physically dependent, one must consume the drug continuously over a period of time, perhaps 10 to 14 days (Courtwright).” When a patient becomes physically dependent on their medication, they should be slowly tapered off when their pain has subsided. This will give their body the ability to adjust to the withdrawal of the medication with less negative effects. Dr. Webster (2007) describes dependence as the body adapting to the blood level of the opioid. Patients will likely show some physical signs of withdrawal if the drug is terminated abruptly. He states that just because a person is physically dependent upon the drug does not mean they are addicted to the medication.

Dr Webster (2007) defines addiction as a person who will show a lack of control of their opiate use, they will have cravings and use even if it is harmful to them. They may be physically dependent on the drug as well. He describes people who suffer from addiction as a person who is willing to sacrifice all parts of their lives for the use of the drug, their life can fall apart but they will continue to seek after the drug. According to Clinical Guidelines for the Use of Buprenorphine it is possible to be addicted to opiates and not dependent on them, this person may have detoxified off of the opiate but still crave the drug which will lead to relapse without psychological treatment.

Symptoms of withdrawal

Withdrawal is very unique to each individual. Opioid dependence withdrawal is physical and opioid addiction has physical as well as psychological withdrawals. “In a pattern unique to each client, symptoms related to substance abuse may be felt for weeks, months, and sometimes years. Clients may be affected by less intense versions of the acute signs and symptoms of withdrawal as well as by other conditions such as impaired ability to check impulses, negative emotional states, sleep disturbances and cravings (Substance Abuse Treatment Advisory)”. Some symptoms of withdrawal are sweating, restless legs, nausea,

sneezing, body aches, diarrhea, vomiting, hot and cold flashes and muscle pain. These feelings of discomfort begin any where between 24 and 48 hours of the last use of the drug. Some of the earliest signs of withdrawal are watery eyes, runny nose, yawning and sweating. "When people have been using opiates heavily, they experience mild withdrawal as soon as their most recent dose wears off. As withdrawal continues, the user feels restless and irritable and loses his appetite. Overall, it feels like the flu, and as withdrawal peaks, the user suffers diarrhea, shivering, sweating, general malaise, abdominal cramps, muscle pains, and generally, an increased sensitivity to pain; yawning and difficulty sleeping gradually become more intense over the next few days (Kuhn, et al. 1998)." The problem with withdrawal is that most opiate users understand that the withdrawal can stop with another use of an opiate. They also understand that they will continue to crave the opiate long after their physical withdrawals have ended and this can make it difficult for them to remain sober. "Chronic substance use causes molecular, cellular and neurocircuitry changes to the brain that affect emotions and behavior and that persist after acute withdrawal has ended (Substance Abuse Treatment Advisory)".

Maintenance Therapy for Opiate Addiction

Methadone is a synthetic opioid that was developed in Germany during the 1940's to decrease the effects of withdrawals for those who had become addicted to opiates. Methadone does not have the euphoric effects that opiates have and in fact it helps stop the euphoric effects of other opiates (www.opiates.com/methadone).

Between 1951 and 1960 death rates began to climb from heroin overdoses in New York. By the middle of 1960 the leading cause of death of young adults between the ages of 15 and 35 was opioid-related deaths in New York. There were more arrests for drug related crimes and no effective ways to make detoxification easier for those who were in jail. A committee was established in 1958 between the Medical Bar and the American Bar Association to help find a way to help those who were addicted to opiates. This committee recommended that outpatient treatment facilities be established in hospitals to deliver opiates to those addicted in a controlled environment. The clients had to dose sometimes three times a day so that they did not go through withdrawals. In the 1960's some states, including New York, had developed programs that would allow for voluntary and involuntary commitment to help clients get through detoxification. This program proved to be very expensive and found that five out of six individuals who had gone through the program had relapsed, committed another crime or overdosed. The Nixon administration increased funds to help stop the use of opioids, primarily heroin from entering the United States. The funds also increased the methadone maintenance program for those who were addicted to opiates (Medication-Assisted Treatment, 2005).

Methadone became a very important option for the treatment of opioid addiction. It provided a safe way for addicts to stop using opiates and helped them lead functional lives. "The most important therapeutic option for women was the development of methadone maintenance. During the early 1960s, Drs. Vincent Dole, Marie Nyswander and Mary Jeanne Kreek, working at the Rockefeller Institute in New York, pioneered the use of methadone, a synthetic opiate they found could block the euphoriant effects of heroin and the addicts craving for that drug" (Kandall, 2010).

In the beginning use of methadone maintenance there was no way to measure the amount of opiates in the blood levels. In 1964 there was an initial study done with two patients who were previously maintained with morphine. They were switched to methadone

maintenance and it was observed that once their dose of methadone was established at 120 mg, they were able to function normally. They did not have drug cravings or anxiety. They also found that the patient did not have negative side effects, they were able to be social in normal settings without the incapacitating effects of heroin or morphine. When the patient was on an effective dose of methadone, the methadone was able to block out the euphoric and tranquilizing effects of opiates. Also the amount of methadone needed over time did not need to increase, it could be held consistent for extended amount of time. Methadone could be administered orally and it had a half life of 24 to 36 hours which meant that it only needed to be administered once a day. It also stopped the cravings for opiates which had previously been a large factor in relapse for those who were addicted. It had few side effects and it was safe and non toxic. In 1965 the study was moved to Manhattan General Hospital in New York City and the study was expanded which again validated that methadone maintenance was an effective way to treat those with an opiate addiction. Dr. Jerome Jaffe, the head of The Special Action Office for Drug Abuse Prevention for the White House in the early 1970's, oversaw the creation of a nationwide public funded program treating opiate addiction (Medication-Assisted Treatment, 2005).

An additional study conducted in the mid 1980's by Ball and Ross used 507 continuing patients and 126 new patients between New York, Philadelphia and Baltimore. They found that the use of methadone decreased the use of heroin and reduced the amount of crime in those areas. This study showed there was a correlation between the function of the patient, the number of services provided by the clinic and the amount of methadone prescribed as a contributing factor to the amount of drug use among the patients. This study also discovered the differences in treatment practices such as urine screening, staff credentials, dosage levels, take home policies and discharge policies (Weschsberg, Kasten, 2007). "By reducing craving and blocking the effects of other opiates, methadone improves patients' physical and psychological health when they are given an adequate dosage for an indefinite period" (Weschsberg, Kasten, 2007).

Methadone is the most common treatment for opiate addiction. It is distributed in a clinic setting where it can be monitored and therapy is available to the client. It has proven to be effective in helping reduce heroin use, it has increased employment abilities and helped to stabilize physical and mental health of individuals (Clinical Guidelines for the Use of Buprenorphine, 2004).

There are regulations regarding who can be placed on methadone replacement therapy. "Federal regulations state that, in general, opioid pharmacotherapy is appropriate for persons who currently are addicted to an opioid drug and became addicted at least 1 year before admission" (Medication-Assisted Treatment, 2005). There are some exceptions to this rule, according to the guidelines in Medication-Assisted Treatment, TIP 43, a pregnant woman can be placed on methadone even if she has used opiates for a shorter time, also someone coming out of incarceration and who has previously had opioid pharmacotherapy. Individuals under the age of 18 should not be treated with methadone unless they have tried unsuccessfully at least two different times of detoxify or engaged in a drug treatment within a 12 month time frame. They must also have a guardian give permission for their treatment.

Buprenorphine, also called Subutex, or Suboxone which is buprenorphine and naloxone together is another type of opioid pharmacotherapy treatment. This medication has less potential for abuse than methadone and it is taken in sublingual tablets. Patients should meet

criteria for dependence and interested in treatment if they are going to be placed on buprenorphine. Buprenorphine should not be prescribed in conjunction with benzodiazepines because it can depress the central nervous system. If both are to be prescribed, lower doses may be necessary (Clinical Guidelines for the Use of Buprenorphine, 2004). According to the Clinical guidelines for the Use of Buprenorphine, buprenorphine may be the form of treatment for adolescents who have been abusing opioids for a short period of time because it may be easier to withdraw from the effects of buprenorphine than from Methadone. Buprenorphine can be prescribed by a doctor and does not have to be given in a clinic setting. The average dose of buprenorphine is 12 -24mg per day, the dose can go as high as 32mg per day. Buprenorphine can be given every other day. Clients who continue to use opiates after they stabilized on buprenorphine should be transferred over to methadone for treatment. Clients who are on buprenorphine also benefit from psychotherapy to help reduce unhealthy lifestyle practices (Medication-Assisted Treatment, 2005).

The 2nd week of October 2010, the Food and Drug Administration approved Vivitrol as an option for opioid dependence. Vivitrol is given by injection that lasts for one month. It was previously only approved for alcohol treatment. Some of the positive traits are that the client would need one shot per month; they only have to make the decision once a month to not use, the rest of the time the medication is already in their system. The downside to this drug is that the cost is approximately \$900.00 per month, insurance has approved the use of Vivitrol for alcohol treatment, it may also eventually be approved for opioid dependence (Alcoholism and Drug Weekly, October 18, 2010).

Naloxone or Narcan has been used to reverse an overdose of opiates. Naloxone will immediately reverse the suppression of breathing. Naloxone can cause the person to go into withdrawal. Joshua Bamberger, MD is working in San Francisco to distribute syringes with Naloxone to needle using opiate abusers. His belief is that it has stopped overdose deaths; he also believes that if an addict believes that you are there to save their lives, they may at some time be ready to believe that you have their best interest at heart and may trust enough to begin methadone or Suboxone treatment (Alcoholism and Drug Weekly, November 1, 2010).

Pregnancy and Opioids

Women who are pregnant and taking opiates are less likely to obtain prenatal care, this may be partially because they are not positive they are pregnant or because of shame regarding their addiction and how society tends to view addiction. "The prevalence of opiate use in pregnant women ranges from 1% to 21%. The higher number reflects use in at-risk populations and does not represent overall use in a more standard obstetric population. Heroin is the most commonly abused illicit opiate and crosses the placenta readily. Heroin enters the fetal tissues within 1 hour of maternal use (Keegan, et al. 2010)." Women who use heroin while they are pregnant may experience more problems with their pregnancy. They are at risk of intrauterine growth problems, bleeding in their last trimester or preterm delivery. Pregnant women who are using heroin need to be tested at the beginning of the pregnancy and throughout the pregnancy for sexually transmitted diseases as well as HIV testing because of the lifestyle that tends to go with the drug lifestyle. These women should be counseled regarding the effects of heroin on the fetus (Keegan, et al. 2010).

Methadone maintenance should be offered to pregnant women who are actively using opiates. Methadone clinics should collaborate with the obstetrician to facilitate appropriate care.

Withdrawal symptoms should be evaluated at each prenatal visit and increases should be coordinated between the obstetrician and the clinic. Withdrawal from methadone is not seen to be appropriate during pregnancy for most women; withdrawal can be seen in the mother as well as the fetus and can possibly cause intrauterine death of the fetus (Keegan, et al. 2010). It is important to work with pregnant women and their families to help them understand that the baby may be born dependent and not addicted. There is a lot of stigma towards women who are using methadone when they are pregnant, they are often judged by others because socially methadone is often times seen as a replacement of opiates, not a treatment for opiate addiction. "Women who give up heroin in favor of methadone treatment engage in less illegal behavior, decrease their rates of needle use and HIV acquisition, experience an improvement in general health and nutrition, receive more consistent prenatal care, show better obstetrical outcomes and are better prepared for parenting (Kendall, 2010)." Methadone provides a steady dose of medication which stops the fetus from experiencing withdrawal.

Babies born to women who have been prescribed methadone for opiate addiction most often experience some type of withdrawal after birth. A study done between 1996 and 2006, showed that there is no correlation between maternal methadone dose withdrawal effects on the infant after birth. The study shows that the important factors are controlling maternal withdrawal and reducing drug cravings (Seligman, et al. 2010).

Conclusion

Opiates continue to be a problem for society. Today we have many first time drug users attracted to prescription pill use. Some reasons include; the availability of medications in the home and the easy access through the internet. Like all illicit drug use, pills become expensive over time and many of those users will turn to heroin because of the cost. Heroin is significantly less expensive.

Opiates have the ability to alleviate physical pain which is very important in the healing process of the body. Patients who are put on opiates for any length of time should be informed about dependence before they begin to take the medication. Some patients will become dependent on the medication because of the length of time they are on the medication. They should be tapered off the medication slowly after they have healed. There are some who after they began taking the opiates, find that they feel good emotionally. Some have made the statement that for the first time in their lives they have felt normal. For those individuals it becomes difficult to stop taking the medication. This population often will doctor shop to continue to get the medications that they are now physically and emotionally dependent on.

When a person becomes addicted to any drug, particularly opiates it changes how their brain reacts to pain, both emotionally and physically. They have a difficult time getting through withdrawals because of the physical discomfort of withdrawals. For many the emotional withdrawals are much more difficult to deal with and may be contributes to the continued use of opiates.

Medications have been developed to help individual addicted to opiates remain sober. Methadone is dispersed in a clinical setting when it is used to treat addiction. Suboxone and Subutex can be prescribed by a physician. The best success for treatment is to use medication in conjunction with psychotherapy. This gives the patient time to work through the issues that

have created the need to be emotionally numb without having to battle the physical and emotional withdrawals.

Medication is used for women who are either dependent or addicted to opiates when they are pregnant so that the fetus has time to grow and develop healthy. The baby will be born dependent and will need to be withdrawn, but they can be administered medication to help them get through the withdrawals. The women should continue to work with a therapist to help them develop the skills to become a healthy parent who no longer needs opiates to deal with emotional issues.

There continues to be a great deal of stigma and misinformation regarding medication management for opiate addiction. Many believe that it is just a replacement for the opiate and this often makes it difficult for people to get help when they have become addicted. Hopefully, once the public is better educated regarding the addiction of opiates and the options that are available for recovery, we may have better success at helping those who have found themselves in the trap of this addiction.

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